

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3183

CERTIFICATE OF DEATH

03176

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b 25 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 1916 Railroad Ave.		d. STREET ADDRESS 1916 Railroad Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James H. Butler		4. DATE OF DEATH March 14, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 26, 1892	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinest		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Yard	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Johnson Butler		14. MOTHER'S MAIDEN NAME Dulcie Colvin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-36-4130	
17. INFORMANT Mimmie M. Butler		Address 1916 Railroad Ave.	
18. CAUSE OF DEATH (Enter on separate line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE(S) (a) Chronic Pulmonary Edema (b) Chronic Myocarditis (c) Chronic Cystitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertrophied Prostate		INTERVAL BETWEEN ONSET AND DEATH 3 da 3 mo 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1961 to March 14, 1961 , that (I) (we) last saw the deceased alive on March 14, 1961 , and that death occurred at 4 P. M., from the causes and on the date stated above.			
22a. SIGNATURE Bruce M. Brumbaugh M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Bruce M. Brumbaugh M.D.		22d. ADDRESS 5609 Main St., Elkridge 27, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/18/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ambrose, Inc. 1328 Sulphur Spring Rd.		25a. REC'D BY REGISTRAR DATE MAR 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1152

CERTIFICATE OF DEATH

11515

Deceased

Married

Married

Place of Birth

Age

Sex

1115 Belmont Ave.

1115 Belmont Ave.

James A. Smith

James A. Smith

June 20, 1962

June 20, 1962

Virginia

Virginia

Johnston Smith

Johnston Smith

Aug. 1911

Aug. 1911

1115 Belmont Ave.

1115 Belmont Ave.

1115 Belmont Ave.

1115 Belmont Ave.

James A. Smith

James A. Smith

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3190 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03177											
1. PLACE OF DEATH a. COUNTY HOWARD b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenwood c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. 97						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenwood d. STREET ADDRESS Rt. 97 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) William Henry JONES			4. DATE OF DEATH Month March Day 22 Year 19 61			5. SEX Male			6. COLOR OR RACE Colored		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH April 30, 1912			9. AGE (In years last birthday) 48 yrs.			10. IF UNDER 1 YEAR Months 4 Days 18 Hours 15 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Frank Jones				14. MOTHER'S MAIDEN NAME Catherine Henderson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Mrs Melinda Jones (same as above)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma. 200.1 DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
21. ACTUAL SIGNATURE William V. Lovitt, Jr., M.D.				21a. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				21b. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
21c. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				21d. DATE SIGNED March 23, 1961				21e. Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/25/61				22c. NAME OF CEMETERY OR CREMATORY Logust Methodist Cemetery			
22d. LOCATION (City, town, or county) (State) Simpsonville, Md				23. FUNERAL DIRECTOR Robert L. Swonder				24a. REC'D BY REGISTRAR Rockville, Md			
24b. REGISTRAR'S SIGNATURE Arthur L. Hume				24c. DATE MAR 30 '61				24d. REGISTRAR'S SIGNATURE			

00157

00158

00159

RECORDS OF THE MEDICAL DEPARTMENT

1. Name of Patient: [illegible]
2. Age: [illegible]
3. Sex: [illegible]
4. Date of Admission: [illegible]
5. Date of Discharge: [illegible]
6. Medical History: [illegible]
7. Physical Examination: [illegible]
8. Laboratory Tests: [illegible]
9. Treatment: [illegible]
10. Progress: [illegible]
11. Discharge Instructions: [illegible]
12. Signature of Physician: [illegible]
13. Signature of Nurse: [illegible]
14. Signature of Pharmacist: [illegible]
15. Signature of Dietitian: [illegible]
16. Signature of Social Worker: [illegible]
17. Signature of Chaplain: [illegible]
18. Signature of X-ray Technician: [illegible]
19. Signature of Laboratory Technician: [illegible]
20. Signature of Hospital Administrator: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

3191

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03178

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b 2 hrs 8mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mabel Adelle Anderson Knust				4. DATE OF DEATH Month Day Year March 21 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10/3/94	
9. AGE (In years lost birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Jessup, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harry S. Anderson				14. MOTHER'S MAIDEN NAME Ida Phelps			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT H. Russell Knust --910 C. St; Sparrows Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 7 1958 to March 21st 1961 , that (I) (we) last saw the deceased alive on March 21st 1961 , and that death occurred at 3:48 AM , from the causes and on the date stated above.							
22a. SIGNATURE Stephen Lee Magness				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D.				22d. ADDRESS Taylor Manor Hospital, Ellicott City, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-24-1961		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town, or county) (State) Howard County Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Edw S MacKarty				ADDRESS Frederick & Wade Ave. 28		25a. REC'D BY REGISTRAR DATE MAR 23 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

3192
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) West Friendship c. LENGTH OF STAY IN 1b West Friendship d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. 40 1 mile West of West Friendship				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 28 03X-2 d. STREET ADDRESS 118 Oak Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DONALD EDWARD MERRICK				4. DATE OF DEATH March 18, 1961 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 19, 1935	
9. AGE (In years last birthday) 26 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN				10b. KIND OF BUSINESS OR INDUSTRY ELEC. SUPPLY			
11. BIRTHPLACE (State or foreign country) MD				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME RICHARD F. MERRICK				14. MOTHER'S MAIDEN NAME ANNA M. MCCARTHY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 1954-1958				16. SOCIAL SECURITY NO. 1954-1958			
17. INFORMANT Mrs Anna M. Brown - 118 Oak Drive				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injury of left chest 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Instant	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased car struck another car from behind			
20c. TIME OF INJURY Month, Day, Year 5 A M p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) West Friendship (County) Howard (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE George E. Burtorf				M.D.			
EXAMINER'S NAME (Type) George E. Burtorf M D				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 3-18-61			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-21-61		22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		22d. LOCATION (City, town, or country) (State) Balto. Md.	
23. FUNERAL DIRECTOR Forley-Crombaugh F.H. - Catonsville, Md.				ADDRESS			
24a. REC'D BY REGISTRAR MAR 24 '61				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

MEDICAL CERTIFICATION

REPLY TO THE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

195

(M)

(1)

1-1-

Arthur S. Kraus

2273195XV2

03180

1103

Howard

Langford

Howard

Illinois City

Illinois City

In reverse order

In reverse order

1

Howard

Langford

Howard

Langford

22

October 18, 1900

Howard

Langford

International Commission

29012

Charles A. Howard, L.S.

1-1-1

Howard, Charles A.

TO DEPUTY ATTORNEY GENERAL: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE HEALTH DEPT

1
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03181
Item 7 Film G283 3/20/61
Item 220 & d, Film G283 3/24/61
1wk

2194
PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Howard
MARYLAND
Pfeiffers Corner
Waterloo and Old Montgomery Road

3. NAME OF DECEASED (Type or print)
First Middle Last
GALVIN COMFORT MILLER

5. SEX
Male

6. COLOR OR RACE
White

7. MARRIED ☒ NEVER MARRIED ☐
W. DOWED ☐ DIVORCED ☐

8. DATE OF BIRTH
May 2, 1903

9. AGE (In years last birthday) 57 yrs

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
T. Edgie Russel Co. Road Construction

11. BIRTHPLACE (State or foreign country)
Thurmont, Maryland

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME
Charles A. Miller

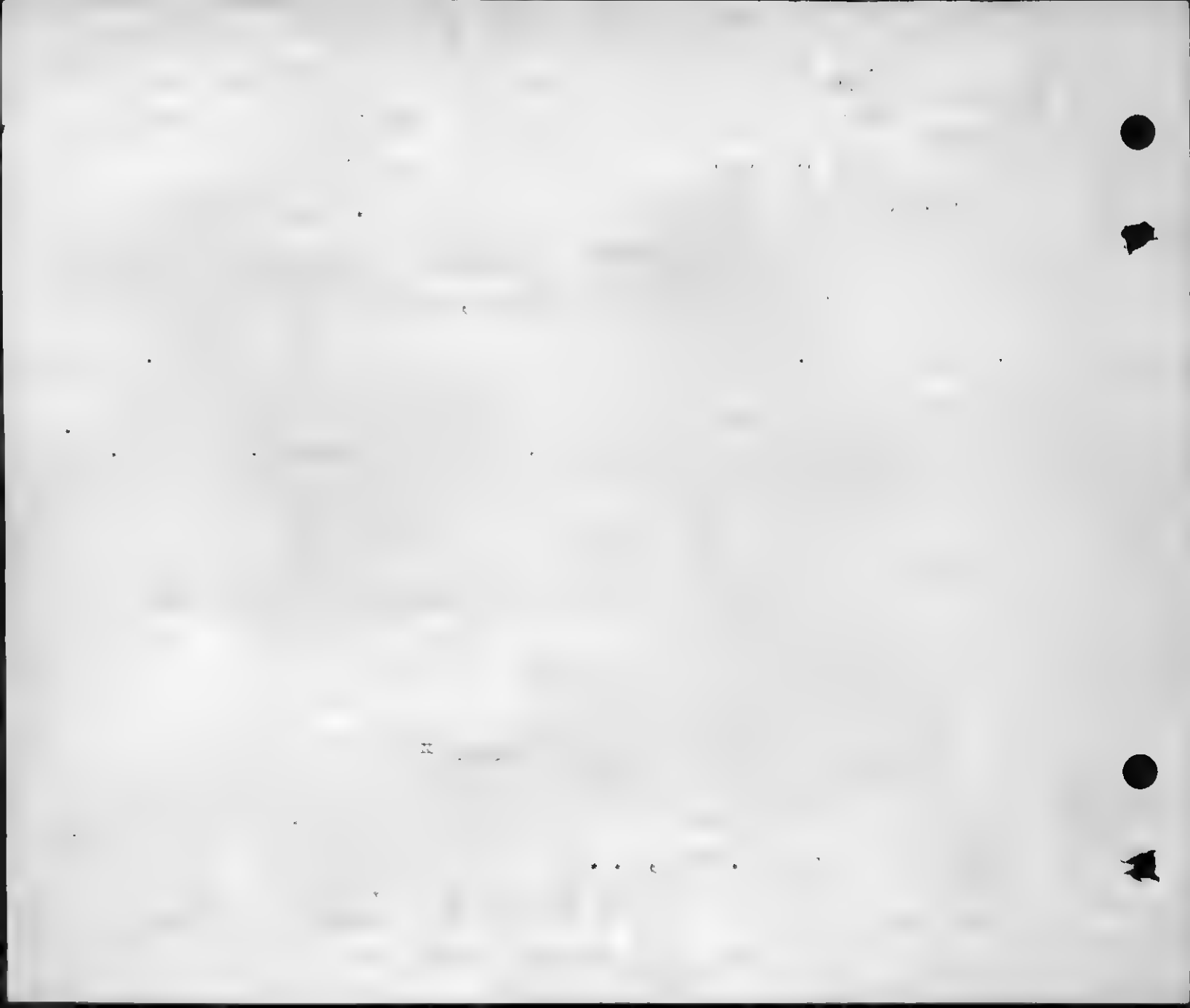
14. MOTHER'S MAIDEN NAME
Eleanor Fogle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes

16. SOCIAL SECURITY NO.
1

17. INFORMANT
Mrs. Evelyn A. Miller-330 N. Market St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Traumatic Injuries
-16 X
DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. (c) DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
20e. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Driver in truck-truck collision
20c. TIME OF INJURY Month, Day, Year
Hour Minute 12:25 p.m. 3/14 19 61
20d. INJURY OCCURRED While ☒ Not While ☐ at work ☐ et work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Highway
20f. (City or town) (County) (State)
Pfeiffers Corner Howard Md.
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED 3/14/61
ACTUAL SIGNATURE Charles S. Petty, M.D.
EXAMINER'S NAME (Type)
22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 22b. DATE THEREOF 3/17/61
22c. NAME OF CEMETERY OR CREMATORY
White Mt. Cemetery
22d. LOCATION (City, town, or country) (State)
Frederick Md.
23. FUNERAL DIRECTOR
Wm J. Tucker & Sons North & South Baltimore 17th
ADDRESS
24. REC'D BY REGISTRAR
24b. REGISTRAR'S SIGNATURE
15 '61



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by a physician or a health officer. The certificate should be executed by the medical examiner or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the medical examiner or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the medical examiner or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3195 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03182

1. PLACE OF DEATH a. COUNTY HOWARD b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Old Annapolis Rd		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS Old Annapolis Rd	
3. NAME OF DECEASED (Type or print) JOHN Robert RIDGLEY		4. DATE OF DEATH March 3 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6 1912	
9. AGE (in years last birthday) 48 1/2		10. IF UNDER 1 YEAR Months 48 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Trans. Gas Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Owen Ridgley		14. MOTHER'S MAIDEN NAME India Warfield	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-3920	
17. INFORMANT Mrs. Ruth L. Ridgley		Address Balto. 23, Md. 324 S. Fulton Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide intoxication and massive smoke inhalation DUE TO (b) Conflagration DUE TO (c) Conflagration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Conflagration of home			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.) Conflagration of home	
20c. TIME OF INJURY Month, Day, Year 4:30-5 a.m. 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Howard (County) Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Bradley King, Jr.		M.D. W. Bradley King, Jr., M.D.	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/61	
22c. NAME OF CEMETERY OR CREMATORY Pine Grove		22d. LOCATION (City, town, or country) Ridgeville, Maryland (State)	
23. FUNERAL DIRECTOR F. C. Higinbotham		24. REC'D BY REGISTRAR MAR 10 '61	
24b. REGISTRAR'S SIGNATURE Charles S. Kraus		DATE SIGNED 3/4/61	

Partial



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

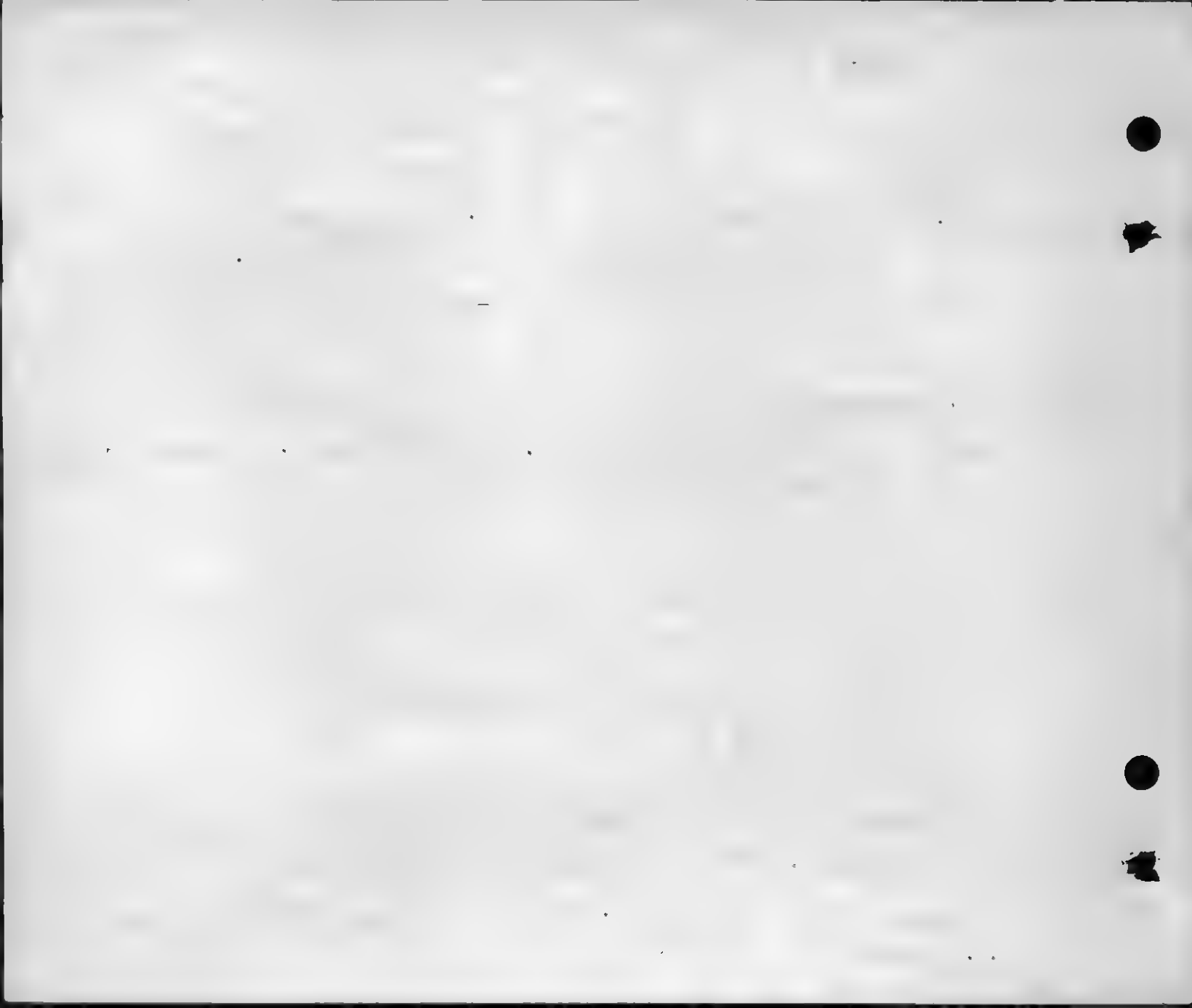
3196

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03183

1. PLACE OF DEATH a. COUNTY <u>Howard</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt. 32</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksville</u> d. STREET ADDRESS <u>Rt. 32</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>FLORENCE SCOTT</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>31</u> Year <u>1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-18-1883</u>		9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>		11. IF UNDER 24 HRS. Hours <u>19</u> Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>				12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME <u>Joseph Stevens</u>				14. MOTHER'S MAIDEN NAME <u>Annie Elizabeth Parlett</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mrs. Fraley Zimmerman, Rt. 32, Clarksville, Md</u> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (a), stating the underlying cause last, (c) <u>DUE TO</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>George E. Purgatorf</u>				EXAMINER'S NAME (Type) <u>George E. Purgatorf</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3-31-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-3-61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>				22d. LOCATION (City, town, or country) (State) <u>Highland, Md</u>											
23. FUNERAL DIRECTOR <u>F.C. Higinbotham, Ellicott City, Md</u>								24a. REC'D BY REG STRAR <u>APR 3 '61</u>								24b. REGISTRAR'S SIGNATURE <u>Curtis L. Hester</u>							

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3197

CERTIFICATE OF DEATH

03184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenwood		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard	
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenwood		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last EMMA DAY SHARP		4. DATE OF DEATH Month Day Year March 28, 1961		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 18, 1871		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George D. Day		14. MOTHER'S MAIDEN NAME Virginia Rebecca Ridgley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Howard Crist, Glenelg, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State) 20h. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 10 days 15 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. I certify that I attended the deceased from July 19 48 to March 28, 19 61 that I last saw the deceased alive on March 11, 19 61 and that death occurred at 8:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles S. Whitaker, B. O. M.D.		ACTUAL SIGNATURE Charles S. Whitaker, M.D.		PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D. Clarksville, Maryland 3-29-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-1-61		22c. NAME OF CEMETERY OR CREMATORY Mt. View		22d. LOCATION (City, town, or county) (State) Alpha, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE APR 3 '61		24b. REGISTRAR'S SIGNATURE Wm. S. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR ATS (4)
TSM 9/59

3198

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03185

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Ellicott City		c. LENGTH OF STAY IN 1b 5 wks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffer's Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Randallstown	
3. NAME OF DECEASED (Type or print) First Mr. George Middle Sheeler Last Sheeler		4. DATE OF DEATH Month March 25, Day 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1891
9. AGE (In years last birthday) 69		10. F UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner of Restaurant		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Conrad Sheeler		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-01-8478	
17. INFORMANT Mrs. Evelyn B. Sheeler		Address Randallstown, Md. 3501 Chapman Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Hypertensive C.V. disease & Cerebral Vascular Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) 5 years DUE TO (c) 5 years		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL - 1, 1958 to MAY 25, 1961 , that (I) (we) last saw the deceased alive on MAY 25, 1961 , and that death occurred on MAY 25, 1961 , from the causes and on the date stated above.			
22a. SIGNATURE Thomas E. Wheeler M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas Wheeler		22d. ADDRESS 3606 Clifmar Rd. Balto. 7, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-28-1961	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		25a. REC'D BY REGISTRAR MAR 30 '61	
ADDRESS 8728 Liberty Rd. Randallstown, Md.		25b. REGISTRAR'S SIGNATURE Charles S. Kline	



3195

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03186

1. PLACE OF DEATH a. COUNTY <u>Hovard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ma</u> b. COUNTY <u>Hovard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lacret</u>			c. LENGTH OF STAY IN 1b <u>45 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lacret</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>High Ridge Rg</u>				d. STREET ADDRESS <u>1 High Ridge Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jacob</u> First <u>Worthington</u> Middle <u>Sander</u> Last				4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 15 1868</u>	
9. AGE (In years last birthday) <u>92 yrs</u>		IF UNDER 1 YEAR: Months <u>9</u> Days <u>2</u> Hours <u>2</u> Min.		IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>general construction</u>			
13. FATHER'S NAME <u>Jacob B. Sander</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT <u>John P. Sander, Laurel, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>9/25</u> , 19 <u>61</u> , to <u>3/30</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3/29</u> , 19 <u>61</u> , and that death occurred at <u>4:20</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert S. McCeney</u>				M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT S. MCCENEY, M.D.</u> <u>402 MAIN ST.</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<u>Burial April 12, 1961</u>		<u>Emmanuel Cemetery</u>		<u>Seagoville Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Caldwell</u>				ADDRESS <u>Laurel, Md</u>		25a. REC'D BY REGISTRAR DATE <u>APR 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanna</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3200

CERTIFICATE OF DEATH

Reg. Dist. No.

03187

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>261 Church Lane</u>				d. STREET ADDRESS <u>261 Church Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Cleaver</u> Last <u>Steelman</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>4</u> Year <u>19 61</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1883</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Penn. R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>David Steelman</u>				14. MOTHER'S MAIDEN NAME <u>Laura Jane Cleaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>717 07 7850</u>		17. INFORMANT Address <u>Mrs Bessie Steelman, Ellicott City, Md.</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest -</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Cardiac Decompensation</u> DUE TO (c) <u>HTAS CVD</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 Yrs</u> <u>10 Yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA OF PROSTATE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-1</u> , 19 <u>61</u> , to <u>3-4</u> , 19 <u>61</u> that I last saw the deceased alive on <u>3-1</u> , 19 <u>61</u> , and that death occurred at <u>3</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>P. Thorpe</u>				M.D.			
PHYSICIAN'S NAME (Type) <u>PETER V. Thorpe</u>				<u>Ellicott City</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u>				ADDRESS <u>Ellicott City, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 10 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained from the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

500

1515

[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Death. There are also sections for the attending physician and the funeral home. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3201

03189

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>				c. LENGTH OF STAY IN 1b <u>X</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>309 Savage-Guilford Rd</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>			
3. NAME OF DECEASED (Type or print) <u>Blanche</u>				f. STREET ADDRESS <u>309 Savage-Guilford Rd</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 19 1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		10. DATE OF DEATH <u>March 23 1961</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Milton Harrell</u>			
14. MOTHER'S MAIDEN NAME <u>Henrietta Floyd</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>George Welch, Savage, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Left Breast -</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>170X</u> (c) DUE TO (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 23 1961</u> to <u>Mar 23 1961</u> , that (I) (we) last saw the deceased alive on <u>Mar 23 1961</u> , and that death occurred at <u>89</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank R. Shipley</u>				22b. DATE SIGNED <u>3/24/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Savage, Md</u>	
22d. ADDRESS <u>Savage, Md</u>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 26, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Savage Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Savage, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. H. Connelley, Laurel, Md</u>				25a. REC'D BY REGISTRAR <u>MAR 29 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

1000

1000

(M)

(P)